
# Mental Health, Chemical Abuse and Dependency Services Division

## Children's Mental Health Plan

## April 2005

# Table of Contents

# Acknowledgments

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) expresses sincere and deep gratitude to the children, youth and their families that this division defines as its mission to serve. The contributions of your input to improve our system of care have been immeasurable and the gains we have made would not have been possible without you. MHCADSD acknowledges there are many miles further along this journey to implement an ideal service system for children, youth and families. In partnership, we will continue to work toward improving our systems and services so they are more effective in meeting the needs of the King County community's children, youth and their families.

We are grateful to the following for their hard work and enduring commitment to children, youth, and their families:

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# Children's Mental Health Plan
# 2004

## Section I
## Introduction

The Children's Mental Health Plan (the Plan) is a guide for MHCADSD, its providers, consumers, and allied agencies when developing policy, programming, service delivery, and quality management for publicly funded children's mental health services. It incorporates recent federal, state, and local mental health system changes, including the emphasis on recovery oriented services and system of care practices. It utilizes the experience of the last 15 years in the King County system of care community and attempts to operationalize core guiding principles into all levels of the mental health system.

MHCADSD developed this plan because the well-being of children, youth and their families is a priority to King County. The complexities that children and youth bring to the mental health system, because they are ever changing and embedded within their families and communities, make it challenging for providers and systems to serve them. In addition, families present to our child serving systems with increasingly greater difficulties and entrenched mental health needs. MHCADSD commits to a renewed emphasis on caring for children, youth, and their families (including those populations of focus in Appendix B) and to implementing effective responses to help them.

In 1990, the King County Mental Health Division (In 1999 the Division became the King County Mental Health, Chemical Abuse and Dependency Services Division, and will henceforth be referred to as MHCADSD) and community stakeholders developed a plan for children's mental health (Foundations for the Future.)[1] The plan's key elements were improved access for children, coordinated care among service agencies, and individualized care for children and families. Changes and trends at the federal, state, and local levels have prompted MHCADSD to build on the past achievements and to plan for continued improvement of services for children with mental health needs and their families.

When the mental health system changed from a fee-for-service system to a managed care service delivery system in 1994 there was a beneficial expansion of the eligibility criteria for children and youth. The result of the expanded eligibility was an increase in provider network capacity—both in number of providers, from 15 to over 35, and in geographic distribution-- to serve children and youth. Additionally, the number of children and youth served annually has increased from approximately 1500 children in 1990, six thousand in 1995, and eleven thousand in 2003.

Since 1998, MHCADSD has led a federally funded children's system of care initiative called Children & Families in Common (CFIC). The main purpose of this initiative is to improve upon system of care efforts in King County and to further infuse system of care principles into every level and in every child serving system in our region. This effort provided many lessons to the child serving community and to MHCADSD and those lessons are incorporated into this plan.

[1] Plans and evaluation documents referenced in this Plan are available upon request. (Appendix A)

In 2003, MHCADSD conducted a system of care survey [2]to gather information about the priorities and direction for system improvements. The priorities point to increased family partnership at every level of the system of care, and the implementation of system of care principles overall.

MHCADSD continues to move toward a system of care model for children and their families. The definition of system of care was first published in 1986 (Stroul & Friedman)[3]. It states that a system of care is: "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families." Stroul further states that "the system of care concept recognized that children and families have needs in many domains and promotes a holistic approach in which all life domains and needs are considered in serving children and their families rather than addressing mental health treatment needs in isolation. (Stroul Issue Brief, 2002).[4] It is upon the system of care model that MHCADSD will continue to improve services to meet the changing and complex needs of children, youth, and families in the King County community.

Contained within the Plan are:

1. A description of the historical, political, and financial context in the current mental health system.
2. A review of current children's mental health services.
3. A vision of an ideal system of care for children receiving mental health services.
4. Areas of emphasis and the recommended action steps for implementation.

## Section II
## Background and Context

Since the 1980s the State of Washington and MHCADSD have been involved in national, state, and local efforts to implement a system of care for children, youth, and their families. MHCADSD established early system of care efforts with mental health and allied service systems. Those early initiatives provided examples of system of care practices within agencies and community provider groups as well as valuable information about how to improve children's mental health services.

Within the past ten years, significant changes have occurred in the public social services sector that requires a reexamination of current services and supports. The changes at the federal, state and local level are as follows:

- Medicaid-initiated cost saving measures, including a change in the basic funding structure of mental health services from fee for service to managed care;
- Increased emphasis on coordination with other publicly funded child serving systems;

[2] Heltiotrope. (2003) System of Care Survey

[3] Stroul, B., & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health

[4] Ibid

- Requirements for increased youth and family participation in treatment and in service policy development and;
- Increased emphasis on demonstrated efficiency of mental health services including the implementation of evidence based practices (see Appendix C for further discussion).

**Medicaid-initiated cost saving measures**

The public mental health system in the State of Washington has been operated under a managed care service delivery model (Prepaid Health Plan) directed by a Federal Medicaid 1915 (b) Waiver since 1993. The Prepaid Health Plan (PHP) now called the King County Mental Health Plan (KCMHP) was initiated in King County 1994. There were, and continue to be, a number of impacts on the public mental health delivery system for children, youth and their families due to the implementation of Medicaid managed care.

One of the impacts was the expansion of the eligibility criteria for children and youth as mentioned above.

The other impacts of the implementation of the KCMHP are structural in nature affecting the service delivery, information systems and payment structures. Typical to managed care service delivery systems are utilization management strategies (e.g. medical necessity criteria, and authorization for services/levels of care). The amount of services a child, youth and their family receive is based on the level of care they are authorized to receive. As with most managed care plans data reporting to a centralized data system is a critical element. The data requirements for the PHP to establish eligibility, facilitate utilization and quality management, and generate payment for clients served has required significant information system sophistication on the part of provider agencies. The payment structure is a case rate payment that results in a shared financial risk between the County and the providers of service.

The KCMHP is evolving due to the passage of a federal law entitled the Balanced Budget Act (BBA). The changes to the KCMHP are significant and will affect the management of the public mental health system in the State of Washington. Some changes resulting from the BBA that KCMHP is aware of and the 1915 (b) Waiver revisions include:

- The implementation of the statewide Access to Care Standards that define eligibility for services under the KCMHP. These criteria narrow the definitions of who can receive services under the KCMHP.
- There are new Medicaid modalities that define the types of services that can be provided to clients under the KCMHP. In some cases these limit the flexibility of the providers in delivering services to clients.
- The 1915(b) Waiver also has more strictly defined what Medicaid funds can be utilized for including how the KCMHP can utilize system savings to reinvest into innovative or specialized services for our clients who need services that don't fall under the traditional Medicaid treatment modalities.

The KCMHP expects that the above changes along with those that are still in development phases will impact the design and delivery of services to children, youth and their families. The entire impact of the changes is not completely known at this time.

King County will work with network providers to ensure that the system of care principles presented herein, guide the service design and delivery decisions that the KCMHP will need to make as the BBA and 1915 (b) Waiver changes are implemented.

## Increased Emphasis on Coordination

Several mandates, recommendations, and audit findings have highlighted the need to increase coordination among child-serving systems. At the federal level, coordinated services are encouraged through a series of grants and technical assistance involving the educational, child welfare, substance abuse, and mental health systems. MHCADSD is a recipient of one of these grants, allowing us to build upon the existing infrastructure and pilot programs that coordinate services among systems. Federal audit results of other child-serving systems have recommended increased collaboration with mental health. At the state level, the Joint Legislative Audit & Review Committee conducted a review of children's mental health and made the recommendation that the mental health system work more collaboratively with other child-serving systems. As a result, the Department of Social and Health Services (DSHS) has made significant efforts at system coordination. The contract with the DSHS Mental Health Division includes specific requirements that each Regional Support Network (RSN) convene cross system coordination efforts. Locally, there are several ongoing efforts at service coordination including the King County Youth and Family System of Care Partnership, the Juvenile Justice Operational Master Plan, and the Reclaiming Futures initiative.

## Increased Youth and Family Participation

In 2001 and 2002, CFIC developed a Family Involvement Plan. This plan describes the value of involving families at every step of the child serving process - from administration through service delivery. The family involvement plan was developed with extensive involvement of families in the system of care.

Family inclusion is essential to the success of the child-serving system. It is how family voice is heard and how valuable family input is implemented throughout the system of care, including policy and program development, service delivery, and evaluation. The goal is for service delivery to be provided in a manner that recognizes families as partners and advisors, not as clients.

## Recent governmental initiatives

Federal, state, and local efforts have created an environment of change in the mental health system. On the Federal level, the President's New Freedom Commission, the Surgeon General's Report, the Health Insurance Portability and Accountability Act and the Office of Financial Management (OFM) have shaped policy recommendations and regulations for state and local governments. Recommendations include increased partnership with consumers and families, increased coordination for child serving systems, increased access and availability of mental health services, and earlier intervention for children, youth and families. The Health Insurance Portability and Accountability Act and the Office of Financial Management (OFM) requirements shape our system, and include data protection and reporting, use of evidence based practices, and independent quality monitoring.

MHCADSD has the infrastructure and the ability to coordinate services at the local level. Several local ongoing efforts have enabled children, youth and families who receive services from schools, child welfare, mental health, substance abuse, and juvenile justice systems to coordinate their care using child and family teams. These teams work at the individual level to coordinate services based on the individual need. Administrative support for these coordinated services includes joint contracting, cross system training, formal agreements, and family and youth participation at all levels of policy implementation.

System of care efforts address all these major changes, providing advocacy, efficiency, and effectiveness that allow the family to decide what services best meet their needs while utilizing existing formal and informal community structures.

## Homelessness

On the local level, addressing the problem of homelessness has been identified as a regional priority. The Committee to End Homelessness in King County (CEHKC) estimates that 500 youth and young adults, and 1900 families including 4000 children are homeless in King County each night.[5]

The problem of low incomes and lack of affordable housing is beyond the scope of this plan, but we know that among the many problems that contribute to homelessness, parental mental illness is one of them. Homelessness disrupts every part of a child's life. This kind of disruption leads to a greater risk of developmental delays and emotional disturbance. The King County Mental Health Plan can partner with housing providers to deliver supportive mental health services that will help stabilize a parent with mental illness in housing. This can be a significant contribution to a long term prevention strategy to reduce future mental illness.

Homeless youth face significantly different issues that contribute to their homelessness. According to CEHKC's Ten Year Plan to End Homelessness, these are "throw away" youth who leave or are told to leave home, who flee abuse or family dysfunction, age out of foster care, or are discharged from institutions. Prevention of homelessness by intervening with children/youth and their families in a way that stabilizes them in their home and community and avoids these conditions is precisely the goal of the Crisis and Hospital Alternative Services currently in development and referenced in this Plan. The recommended continuum of care contained in this Plan calls for interventions that de-escalate crises and keep children/youth in their homes; collaboration with allied systems serving the child/youth and family, and ensures culturally competent services that are relevant to the family.

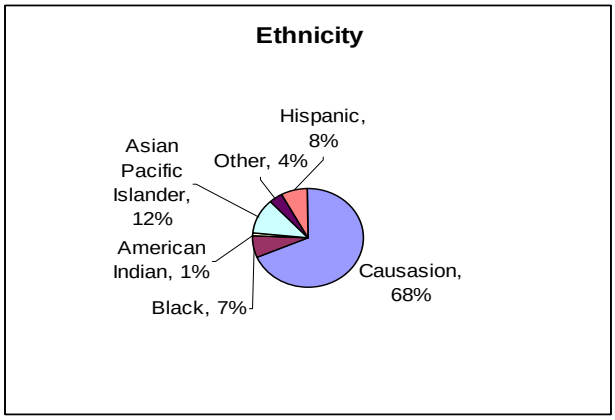
## Population

King County according to Census 2000, has a population of 1.74 million people. Children ages 0 to 19 years of age make up approximately 25% (434,736) of the total King County population. While the public mental health system serves children/youth through 21 years of age, the data for children through age 19 years is more readily available. Additionally, the census indicates that King County is a culturally diverse

[5] "Our Community's 10-year Plan to End Homelessness," 2004

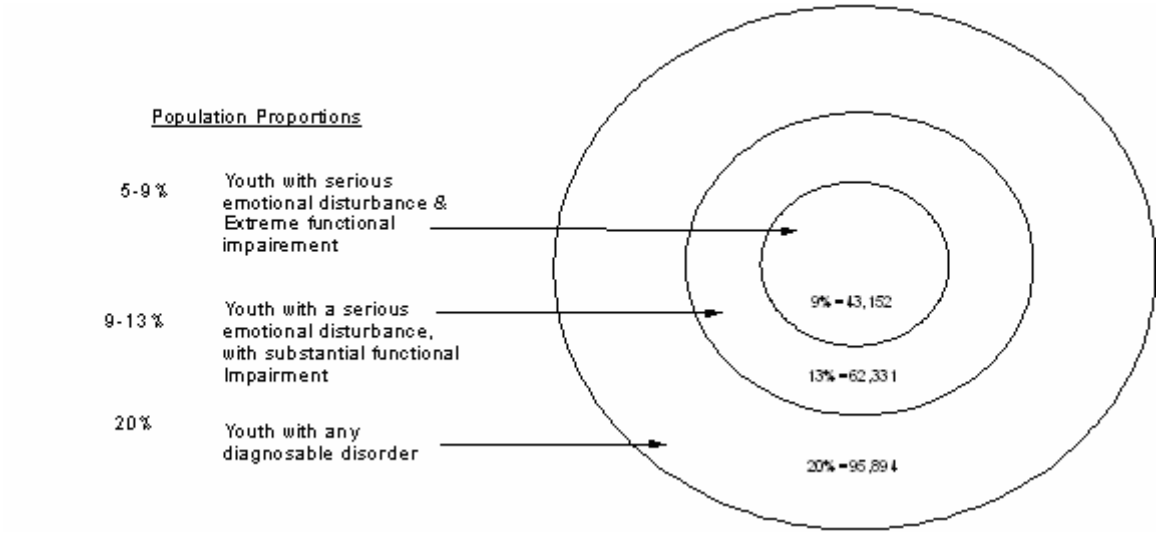
community. The ethnicity distribution of King County's children/youth aged 0 to 19 years is depicted in Figure 1. below.

Figure 1. Ethnicity of Children/ Youth




There have been a number of studies regarding the prevalence of emotional disturbance among children, particularly those aged 9-17 years. A very limited number of studies have been completed on children younger than nine years of age. These studies were summarized into a federal Center for Mental Health Services (CMHS) report entitled *Mental Health, United States, 1996*. The figure below depicts what the studies indicate to be prevalence of emotional disturbance among 9-17 year olds. The report indicates that children/youth living in low socioeconomic circumstances have a higher prevalence rate than children living in high socioeconomic circumstances. The report recommends that the high end of the prevalence ranges indicated below should be utilized when calculating prevalence children/youth living in low socioeconomic circumstances.

Figure 1. Prevalence of Emotional Disturbance (9-17 year olds)




King County Mental Health Plan (KCMHP) has specific responsibility for children/youth who are recipients of Medicaid. Children/youth whose family's income is less than 200% of federal poverty levels ages 0 -17 years are eligible for the State Children's Medicaid

program. For the calendar year 2003 there were a total of 143,854 children/youth ages 0 to 17 years of age. The KCMHP could expect that 18,701 (13%) children/youth could meet medical necessity for its outpatient programs according to the above prevalence rates. In calendar year 2003 the average monthly outpatient caseload was 6,454 children/youth. In all services (including crisis services and inpatient) 10,239 unduplicated children/youth were served.

The children/youth served in the KCMHP during the period September 2003- August 2004 are described below. The total unduplicated number of children/youth served in the above period is 9,615. The median age of children/youth served is between 11-12 years of age. The age distribution is shown in Figure 3 below.

Figure 3.

Age Breakout

| Age | N | % |
|---|---|---|
| Under 6 | 960 | 10.0 |
| 6 - 8 | 1739 | 18.1 |
| 9 - 11 | 2238 | 23.3 |
| 12 - 14 | 2376 | 24.7 |
| 15 - 17 | 1864 | 19.4 |
| 18+ | 438 | 4.6 |
| Total | 9615 | 100.0 |

The KCMHP medical necessity criteria require that the needs of children/youth be described either by diagnosis or conditions and circumstances. Each child should have no more than one primary diagnosis, although not all will have a primary diagnosis. By looking at the diagnosis group into which primary diagnoses tend to fall and the conditions reported, some very general ideas can be gleaned about what children are being treated for.

The top five primary diagnosis groups are:

- Adjustment disorder (33%)
- Disorder of development (23%)
- Depression (12%)
- Anxiety (11%)
- Bipolar disorder (2%)

Dropping down to the level of specific primary diagnoses (rather than primary diagnosis group), the top five are:

- Adjustment disorder with both emotional and conduct components (9%),
- Unspecified adjustment disorder (8%),
- Attention deficit disorder with hyperactivity (8%)
- Post-traumatic stress disorder (6%)
- Oppositional defiant disorder (6%)

About 92% of children had more than three reported conditions at assessment. About 2% had none. The top ten conditions at assessment were:

- Family Discord (11%)
- Divorce/Separation of Parents (10%)
- Substance Abuse in Parents (7%)
- Inadequate Parenting/Child Neglect (5%)
- Domestic Violence (5%)
- Mental Illness in Parents (5%)
- Multiple Systems Involvement (5%)
- Troubled Sibling (4%)
- Parents Involvement in Criminal Justice System (4%)
- Out-of-Home Placement (4%)

From the data above one can see that children/youth come to the mental health system for treatment of a variety of diagnoses and conditions. The treatment system must be competent, flexible, and well equipped to address these needs and to assist children/youth and their families to participate fully in school and community life and to reach their full potential.

## Section III
## Current Mental Health Continuum of Care

The largest component of the King County mental health system for children is outpatient services. Outpatient mental health services are shaped by MHCADSD policies that integrate many of the values and principles of the system of care such as: requiring that services are family driven, that care is individualized and tailored to the needs of the child and family, that services are culturally competent, and that there is coordination and collaboration with other services. In addition to outpatient services, MHCADSD also provides crisis services, short stay residential treatment, and authorization of inpatient services. MHCADSD partners with other systems to provide specific services. The current array of services provided by MHCADSD and in partnership with other systems is described below.

### Outpatient Services

Important goals of outpatient mental health services are to ensure that treatment services are provided in partnership with the family, in the community where the family lives, and that children and families' well being is improved. In developing an outpatient mental health system, an emphasis is placed on ensuring that children receive a comprehensive assessment that is strength based and is utilized in the development of an individualized and tailored care plan.

MHCADSD has implemented the model of wraparound process for many multi-system involved children. This model of care emphasizes family-driven care, strength-based treatment, and cross-system coordination. Although the King County Mental Health Plan (KCMHP) policy and procedure manual and agency contracts have incorporated some language that supports child and family driven services, system coordination and

culturally competent services, the system does not yet systematically implement the wraparound process for children and youth with the highest needs.

In addition, MHCADSD continues to hear from stakeholders and families that they need increased effectiveness and appropriateness of services for clients. Increased partnership with clients and their families to hear their concerns and their solutions continues to be an area of focused effort in the mental health administration and provider network.

## Crisis Services

The current mental health service system ensures that enrolled clients and non-enrolled individuals have access to crisis services 24 hours day/7 days a week. Mental health crisis services include face-to-face interventions that focus on stabilization of the crisis and linkage for children and families to other needed resources.

Children who are enrolled in outpatient services receive crisis services through their outpatient provider. Children who are not enrolled in outpatient services receive their crisis services through a specially designated countywide crisis response team. Both enrolled and un-enrolled children also have access to inpatient diversion beds – short stay (14 day) beds that help the child and family weather the crisis and prevent hospitalization. Enrolled children have access to longer term crisis residential services (30 days) that help child and families while waiting for or returning from Children's Long Term Inpatient Program (CLIP) facilities.

Although these services generally respond to needs in our community, MHCADSD recognizes that more needs be done to avert crises and prevent hospitalizations and is in the process of redesigning this part of the service system.

## Inpatient Hospitalization (acute and long term)

Children who are experiencing an acute crisis, meet the medical necessity criteria for an acute level of care, and cannot be diverted to an inpatient diversion resource have access to inpatient hospitalization. MHCADSD authorizes the requests for hospitalization when children meet medical necessity criteria. MHCADSD does not currently hold contracts with the inpatient hospitals.

The goal of hospitalization is to stabilize the crisis, prevent further decompensation, and to facilitate the child's return to his or her community and family. Six hundred and fifty-six children (0 through 21 years of age) were hospitalized in 2003. The number of hospital beds available for children in the state of Washington is significantly less than the need for hospital beds and a number of community hospitals have either closed their psychiatric hospital beds or a considering doing so. It is MHCADSD's intention to reduce the number of children who are hospitalized by using alternatives to hospitalization, and to more effectively serve children so that hospitalization is less necessary. MHCADSD is developing a children's crisis and hospital alternatives plan, referenced above, to more effectively address the needs of children who are at risk for hospitalization.

In addition to local community psychiatric inpatient services, children who need longer-term treatment may be admitted to state-managed CLIP facilities.

In 2003, fifty-three children were placed in CLIP facilities with most children staying more than 6 months. Although MHCADSD recognizes that some children need long term treatment, we believe that most children and families are better served by remaining in the community with appropriate services and supports. The children's crisis and hospital alternatives plan is the approach that will be used to reduce the number of children placed in CLIP facilities by intervening earlier and more effectively.

## Collaborative Services

In an effort to provide quality services to children and to collaborate with other systems, MHCADSD partners with the state Division of Children and Family Services (DCFS) to fund the Interagency Staffing Teams, short term and longer term crisis beds, and the Blended Funding Project.

In partnership with the Juvenile Justice system, MHCADSD has implemented two evidence-based programs, Multi-Systemic Therapy and Functional Family Therapy, to address the needs of adjudicated children with mental health issues and their families. Though these two programs serve a limited number of children in King County, they provide additional information in understanding how to more effectively identify children who are mutually served in the mental health and juvenile justice systems and to connect them to the services they need.

## Family Advocacy Efforts

MHCADSD works in partnership with family groups to ensure their voice is solicited and incorporated in the system of care. Independent family groups provide training on the wraparound process, on parent partnering, and on community building. In addition, MHCADSD contracts with providers to include family voice and promote family partnership through the Networks of Support. These Networks of Support provide the means for parents and caregivers to support and share information and resources with each other while navigating the child serving systems. In addition, MHCADSD is designing, in partnership with families, a local peer to peer support services system for family members of children and youth receiving publicly funded mental health care.

## Training

Much has been learned over the past several years about improved strategies for serving and stabilizing children/youth and families. That knowledge is well developed and effectively implemented in service delivery by some agencies, in some programs, and by some clinicians. It is the goal of this plan to more broadly disseminate the information and training needed to build those skills throughout the children's mental health system. Technical assistance and training will be a part of the long range plan to promote implementation of best practices.

# Section IV
# Vision for the Future

To advance the previous work for children, youth and families, and to emphasize full family partnership, recovery- oriented practices, and coordinated care, MHCADSD has developed a vision for services for children, youth and their families.

> *The King County Mental Health Plan and its providers partner with families, their communities, and allied service providers, to help children and youth to participate fully in school and community life and to reach their full potential.*

Mental health services shall continue to focus on keeping children and youth in stable environments (schools, neighborhoods) and in their homes. The services shall promote strengths, skill building, and advancement along developmental stages, and crucial attention to the unique culture of the family. Care plans shall be designed in full partnership with the youth and family.

Service models in the mental health system will include recovery-oriented services focused on developing and building upon assets and strengthening the resilience of children, youth, and their families. Services shall include utilization of evidence based and best practices that achieve outcomes that are meaningful to children, youth and their families as well as outcomes that provide efficiencies to systems.

As a result of implementing the action steps to achieve this vision, MHCADSD will endeavor to attain:

1. A mental health system that achieves better outcomes for children, youth and families.
2. Earlier intervention with younger children.
3. A more effective delivery system for the populations of focus. (Appendix B).
4. Family and youth involvement in every aspect of the mental health system.
5. Availability of the wraparound process to every child and youth involved with multiple systems.
6. Increased effectiveness of system partnerships that result in better communication and easier transitions between systems for children, youth and families.
7. Implementation of recovery oriented services for all clients.

MHCADSD believes that addressing the areas of emphasis identified below will assist the system to achieve the vision of this plan.

1. Family and youth partnership
2. Recovery oriented services
3. Wraparound
4. System collaboration

**Family and youth partnership**

Partnership with families and youth entails sharing information and power in care planning, in service provision, and in policy development. In care planning, families and youth need full access to accurate information in order to make informed decisions.

Decision-making is a shared process through the mutual exchange of information between families and those assisting them. Families (as defined by the youth and family) are a constant in children's and youths' lives, and professionals are most effective when they support and partner with the family and youth. Ideally, families and youth are viewed as assets and experts and each family's culture is a resource for creating solutions that work for them.

Youth and families can be a resource for service delivery through peer support, as resource managers, and as advocates. Youth and families can assist client families more meaningfully because they share many of the same experiences. They have credibility with client families because of this experience; and they also have wisdom, skills, and resources to bring to the care planning process.

In addition to participation in care planning and service delivery, the youth and family voice is important and should be solicited for policy development and implementation. Involving youth and families in policy planning helps to ensure that the impact of those policies is relevant to them.

Family and youth partnership is essential to all future changes in the child and family service system. It is the area, beyond all others, that is most crucial to providing effective and relevant service to the child, youth and family client population.

| **Recommendation** | **Implementation** |
|---|---|
| MHCADSD and providers shall assure that family and youth are full partners in decision making at treatment/care sessions or meetings. Families and youth will work with clinicians to define the issues to address, the services to address the issues, and to evaluate and make changes to the care plan as the families' and youths' needs change. | 2005 |
| MHCADSD and providers shall assure that families and youth share in decision making with clinicians in deciding about the means to implement the care plan such as weighing costs of the care plan, deciding on priorities, working within agency mandates and clinical appropriateness. | 2005 |
| MHCADSD and providers shall assure that clinicians, youth and families identify the cultural resources of the youth and family and develop solutions to utilize those resources in care planning. | 2005 |
| MHCADSD and providers shall support families to network with each other by connecting families to other families and connecting families to family groups. | 2005 |
| MHCADSD and providers shall support family involvement as service providers in the service delivery system. | 2005-2008 |
| MHCADSD will work with the state Mental Health Division on credentialing requirements for youth and family members as peer supports. | Current and ongoing |

| | |
|---|---|
| MHCADSD and providers shall assure that family members are involved in provider service planning committees, quality committees, and program evaluations. | 2005 and ongoing |
| MHCADSD will assure family involvement in system service planning and development. | Current and ongoing |

**Recovery Oriented Services**

Recovery oriented services enable children and youth to acquire skills and restore their developmental process while managing the realities of a mental health disorder. Recovery oriented services are those that professionals can offer to help children, youth and their families to develop resiliency and acquire and improve skills that assist them in coping and thriving. (Appendix D for further discussion).

| **Recommendation** | **Implementation** |
|---|---|
| MHCADSD and the provider network shall increase the focus on the skills and assets (including specific family cultural assets) that youth and families bring to the clinical setting and use of those assets in care planning. | 2005 |
| The MHCADSD tier 3B authorization process will include a review of the providers' assessments of children's developmental stages and utilization of skills and assets in care planning. | 2005 |
| MHCADSD, in partnership with providers, youth, and families, shall publish developmental stage guidelines to assist in implementing the recovery model for children, youth and their families. | 2006 |
| MHCADSD contract compliance site visits will incorporate review of providers' recovery practices. | 2005 and ongoing |

**Wraparound Process for Multi-System Involved Youth and their Families**

The wraparound process involves creating a team of people significant to the youth and family, including natural supports that are culturally relevant, to assist the youth and family through difficult times in their lives. The team helps the family to identify needs across all life domains and then utilizes the strengths and resources of the child, youth, family, and community to create and implement a care plan. Important goals of wraparound are that the child and family improve in their functioning and that the team grows and changes, eventually evolving into a community of people that supports the family after formal services have ended. The King County Wraparound Process Model is being developed and will be published as a practice guideline.

| Recommendation | Implementation |
|---|---|
| During the tier 3B authorization process, MHCADSD staff will encourage the use of a wraparound team with multi-system involved children and youth. | 2005 |
| MHCADSD will support continued technical assistance to the community regarding wraparound. | 2005 and ongoing |
| MHCADSD contract compliance site visits will include monitoring wraparound principles established in the KCMHP P&P. | 2005 and ongoing |
| MHCADSD will work with providers to evaluate the goal and implications of ensuring that all multi-system youth and their families will have a wraparound team. | 2005 |
| The wraparound process will be published as guidelines. | 2006 and ongoing |
| MHCADSD contract compliance site visits will include review of the use of wraparound for tier 3B multi-system involved children. | 2006 |
| MHCADSD will implement policy and procedure changes based on the results of the wraparound evaluation. | 2007 |

## System Collaboration

System collaboration is a process of developing and maintaining formal and informal relationships with other child serving systems to effectively address the needs of shared children, youth, and their families. System collaboration is a cornerstone of system of care principles and a necessary component to achieve appropriate, coordinated, and effective services for children and their families. MHCADSD will lead collaboration efforts between child serving systems.

MHCADSD and allied child serving systems (e.g. Juvenile Justice, Child Welfare, Education, Developmental Disabilities, Community and Human Services, and direct service providers) have made excellent progress in coordinating care for children and families in King County. System collaboration occurs on a variety of levels and it is concentration on collaboration at all levels that allows true integration of services to occur. MHCADSD will continue to take community leadership to further system collaboration by assuring that administrative activities promote and support policies, training, and services that enable the child serving system to function as partners and to integrate where needed.

**Continued activities:**

1. MHCADSD will continue to chair or co-chair a core leadership group to further system of care principles across King County. The current iteration of this group is the King County Youth and Family System of Care Partnership.

2. MHCADSD will collaborate with all child-serving agencies and will continue to specifically collaborate with local and state representatives of Juvenile Justice, the Division of Children and Family Services, the Educational System, Public Health, and the Division of Developmental Disabilities (local and state).
3. MHCADSD will continue to identify the cross system coordination needs through information gathered from cross-system bodies such as the King County Youth and Family System of Care Partnership, the Interagency Staffing Teams, and youth and family groups.
4. MHCADSD will continue to maintain and improve informal structures between systems, as well as formal arrangements such as working agreements.
5. MHCADSD will continue to pursue shared funding for shared clients as one means to further intersystem integration and coordination.
6. MHCADSD will continue to assist child-serving systems to move from cost shifting towards cost sharing in developing and funding services.

# Section V
## Guiding Principles

In addition to the above areas of emphasis, MHCADSD intends to implement the system of care principles as outlined below. These guiding principles will direct MHCADSD and its providers as they develop policies and provide services to children, youth and families. MHCADSD will periodically review the service delivery system to understand the successes and challenges of incorporating these guiding principles and to continue to improve the system of care.

### Mental Health Guiding Principles

The King County Youth and Family System of Care Partnership (KCYFSOCP) adopted system of care principles with the intent that each child serving system would use these principles to guide its services to all of the children, youth and families they serve. MHCADSD has adapted those principles as follows:

**Accessible Array of Services:** Mental health services are offered in a timely manner with family-friendly schedules and locations. In addition, there will be available a continuum of services from least to most restrictive that can be adapted to meet the needs of the child, youth and family.

**Community Based:** Mental health services are provided in the setting that is preferred by the child and family and delivered in the least restrictive setting possible. More restrictive settings, such as residential treatment or hospitalization are the service settings of last resort.

**Culturally Competent:** The capacity to accept, respect and give attention to cultural differences; to understand the knowledge, values, beliefs and customs belonging to a particular family and cultural community. Services are provided within the context of the family's culture, utilizing the assets and strengths the family and community's culture offers.

**Collaborative and Coordinated Services:** The services from one agency or system are planned in concert with another agency. Care plans are complementary between

agencies. Mental health clinicians will coordinate with other professionals and family members to ensure the best outcomes for children and to reduce redundancy in service.

**Early Intervention:** Children and their families needing services shall be identified as early as possible and connected to appropriate services. Mental health services shall emphasize early intervention with schools and in the community, and clinicians shall educate caregivers about the importance of early intervention**.** Allied systems shall be systematically trained to identify and refer children who may present with mental health issues.

**Family Driven:** Family voice is sought and implemented in policy development, program development, and service delivery. Families are seen as partners and advisors, rather than clients.

**Individualized Services:** Services are tailored to the particular strengths, assets, resources, and needs of the youth and family. The provider creates and accesses services that match the family's need.

**Natural Supports:** Clinicians will assist families in identifying or developing natural supports for purposes of developing the family's ongoing capacity to meet its needs. Examples of natural supports include family, friends, neighbors, church members, and coaches. Natural supports must be enlisted to participate with the family, to advocate for them, to provide informal resources, and to strengthen the community. Natural supports shall be explored first when determining ways of meeting the families' needs.

**Recovery:** "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles…to live a satisfying, hopeful and contributing life even with limitations caused by [an] illness." (William Anthony) A process that enables youth and their significant adults to understand and manage the realities of the illness or situations that are impinging on the youth while enabling acquisition of skills and restoration of the developmental process. Recovery oriented services are those that are offered to help children and their significant adults develop skills and foster the restoration of the developmental process.

**Shared Funding:** When children and their families are served by multiple systems, the agencies and families shall develop child and family teams to coordinate services and to avoid unnecessary duplication. Agencies and systems will share, or blend, or braid funds to the extent possible.

**Strength Based:** All families and youth have strengths despite the difficulties they encounter. A family and youth Strengths Inventory elicits the resources and assets that the family and community can utilize to address problems they face.

## Summary of Proposed Changes

The following grids outline how the guiding principles of the mental health system will direct the planned changes and improvements in MHCADSD Children's Mental Health Plan. These changes are organized into clinical services and administrative functions.

# Section VI
# Future Continuum of Care Grid

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Crisis and Hospital Alternative Services.** | First crisis contacts for unenrolled children and youth will emphasize keeping them in their own homes with their current caregivers.<br><br>Providers will attend to early intervention opportunities within the family.<br><br>Families and providers partner to develop skills to manage children and youth in the community.<br><br>Providers will stabilize the crisis utilizing a variety of services/methods including in-home face-to-face outreach. | Review current crisis system services for enrolled and unenrolled children and youth to determine program structure adequacy.<br><br>Make changes to policy language in KCMHP P&P subsequent to approval of crisis services plan.<br><br>Add to the KCMHP P&P language that requires crisis providers have qualifications/training in accessing community resources and utilization of natural supports. | 2005 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Crisis and Hospital Alternatives Continued.** | Families are educated on array of services to prevent acute inpatient and long term inpatient stays.<br><br>Natural supports are identified and utilized as a crucial part of hospital alternatives and crisis services.<br><br>Child and family team is called by enrolling agency or crisis services provider if not enrolled.<br><br>When making decisions about hospital diversion, the child, youth, and family's culture is emphasized when designing alternatives.<br><br>Child, youth, and family's strengths are identified and utilized in the diversion/crisis plan. | | 2005 and ongoing |
| **Access to Community Resources/Referral** | Any mental health provider that a child, youth or family calls for services will have the ability to provide a range of service information (mental health and other allied service provider) to families that allows them to choose the best fit for their needs.<br><br>Providers shall also refer to the Crisis Clinic Community Information line for an expanded list of resources for families. | Strengthen KCMHP P&P language that families have information available to them to make as many informed choices as possible.<br><br>Add to the KCMHP P&P language encouraging referral to the Community Information Line for additional resources. | 2005 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Care**<br>• **Access**<br>• **Intake/Assessments**<br>• **Engagement into services**<br>• **Ongoing services**<br>• **Sustained relationship with services**<br>• **Crisis plans/crisis services**<br>• **Coordination**<br>• **Early intervention**<br>• **Outreach activities** | Providers will list the array of mental health services available. The child, youth, and family in partnership with the clinician can choose the most appropriate option.<br><br>There will continue to be a flexible and responsive array of services, including family friendly times and locations.<br><br>Intakes/Assessments will gather information on the child, youth and family's natural support systems, strengths, and other service involvement, in addition to historical and presenting issues.<br><br>Provider intakes/assessments will gather information that rules out dual diagnosis, e.g. developmental disability, substance abuse and medical conditions.<br><br>Provider intakes/assessments will gather developmental history of child or youth.<br><br>Providers will, in partnership with the family, assist the youth and family in achieving developmental milestones as published in the KCMHP P&P.<br><br>Providers, in partnership with families, will link child or youth with normalized and developmentally appropriate community activities. | Add language in the KCMHP P&P strengthening natural support information gathering at intake.<br><br>Strengthen P&P language regarding access to information and partnership in decision making.<br><br>2005 Site Visits will focus on agencies providing child and family services to determine the principles of family access to information, voice and choice are followed.<br><br>Developmental Stage Guidelines for children and youth added to the KCMHP P&P. | Simple P&P changes Jan 2005<br><br>Simple P&P changes Jan 2005<br><br>2005<br><br>2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Services cont.** | Providers shall ensure that each life domain of the assessment includes the youth and family's articulation of both the need and the goal for the domain. | Add to the KCMHP P&P language that incorporates the child or youth and family's statement of need in the assessment. There shall be goals for each identified need. | 2005 |
| | Family to family and youth to youth support services will be available to children, youth, and their families in outpatient services.<br><br>Providers shall utilize family to family or youth to youth, or natural supports for the ongoing sustained relationships or for assistance in engagement with the service system. | A peer to peer system for children, youth & families will be developed (in partnership with families) and supported by the County as resources allow. – including Technical Assistance (TA) (see TA in administrative section). | Peer to Peer System 12/05 |
| | Providers will ensure that ongoing services will identify the skill sets that youth and families need to attain their goals. Interventions will assist the family and youth to obtain the needed skills. Providers will assist youth and families to generalize acquired skill sets to other environments. | Strengthen P&P language regarding skill identification and acquisition. | 2005 and ongoing |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Continued.** | Providers shall actively work to keep families and their child and family teams engaged in care, especially those who are multi-system involved. There shall be a plan for reconnecting the child, youth and family to ongoing care. | Strengthen KCMHP P&P language reflecting need for increased engagement of families of multi-system involved children. | 2005 |
| | Providers shall utilize family to family support services in efforts to engage or re-engage families into care. | 2005 Site visits shall focus on efforts to engage multi-system involved families. | 2005 |
| | Providers will assure that families are informed of and have opportunities to be connected to family groups for support and resources. | Add KCMHP P&P language encouraging providers to inform families of and encourage connection to local family groups. | 2005 |
| | Providers shall ensure that there is an emphasis on moving towards building individual and family capacity and supports so the child or youth and family is increasingly able to meet their own needs through the natural support community and through personal resources. | Strengthen recovery model language in the KCMHP P&P as it pertains to children, youth and families. | 2005 |
| | Providers shall ensure the incorporation of family culture in care planning | Strengthen KCMHP P&P language to incorporate culturally relevant services and supports in the care plan; including levels of acculturation. | 2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Services Continued.** | Providers will emphasize the use of interpreters when needed and attempt to eliminate the use of children and youth as interpreters. | Add KCMHP P&P language that limits the utilization of children and youth as interpreters. | 2005 |
| | Providers shall engage multi-system involved youth and their families in a wrap-around care process. Families may decline the wraparound process if they choose. | Add KCMHP P&P requirement that 3B multi-system children and youth will be served through a wraparound process. | 2006 |
| | Providers in partnership with families shall participate in key elements of the wraparound process that includes:<br>• Family driven care plans<br>• Development of a child and family team<br>• Culturally relevant services<br>• Coordination between systems<br>• Clearly delineates roles and responsibilities of members on the child and family team<br>• Regular team contact with individual members and as a group. | Develop and add the Wraparound Process Guidelines to the KCMHP P&P<br><br>Tier authorization for 3B multi-system involved children and youth will encourage the use of the wraparound process in 2005. | 2006<br><br>2005 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Services Continued.** | | Site Visits will test review key elements of the wraparound process<br><br>KCMHP P&P will require the use of wraparound process for 3B multisystem involved children and youth if families are in agreement.<br><br>Site Visits will monitor for the wraparound process for multi-system 3B children.<br><br>Provide continued training in best practices such as the wraparound process. See TA section in administrative grid. | 2005 –2007 for all<br><br>2006<br><br>2006-2007 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Outpatient Services Continued.** | Crisis Plans will be developed by the child, youth and family – describing in a step wise fashion how to de-escalate the crisis using the child, youth, and family strengths, natural supports, and cultural assets. | Review current crisis services system for enrolled and unenrolled children to determine program structure adequacy. | 2004-2005 |
| | Providers shall ensure that crisis plans emphasize keeping the child and youth at home, in the least restrictive setting, whenever possible. | Develop resources to assist families in keeping children and youth in the community – part of crisis services plan. | 2005-2006 |
| | Providers shall ensure that multi-system involved families have a crisis plan involving allied systems in the interventions. | MHCADSD will develop crisis response guidelines and protocols for providers working with enrolled children, youth, and families in crisis – part of crisis services and inpatient diversion plan. | 2005-2006 |
| | Crisis plans will utilize the family's natural supports as a first step in a sequence of interventions. | Review KCMHP P&P to ensure that crisis service language is relevant to children, youth and families. | 2005-2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Specialty Services**<br><br>**Crisis Response Services**<br><br>**Interagency Staffing Team**<br><br>**Functional Family Therapy**<br><br>**Multisystemic Therapy**<br><br>**Juvenile Justice Liaison** | King County shall continue to implement treatment and care strategies that are effective with the inclusion of promising practices, best practices, and evidence based practices.<br><br>There will continue to be interagency and family community teams that meet to address the needs of children and youth with complex multi-system issues, including the review and approval of flexible funds.<br><br>There will continue to be consultants in the community that assist in convening child and family teams for multi-system involved families<br><br>Providers shall continue the development of relationships with King County Superior Court to ensure coordination for shared children and youth.<br><br>The juvenile justice liaison shall ensure that care planning for juvenile justice involved youth address, the impacts and reduction of criminal behavior by the child or youth. | Continued implementation of best practice and evidenced based programs such as Wraparound Process, Functional Family Therapy, and Multisystemic Therapy.<br><br>MHCADS will continue to ensure an interagency mechanism to review the needs of children and youth with complex multi-system issues. | 2005-ongoing |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Inpatient Coordination** | There is a continued value in the King County Mental Health Plan to limit the use of restrictive settings and hospitalization for children and families. | Working relationships with hospitals shall emphasize shared care planning between hospital staff and community mental health child and family teams. | 2005 and ongoing |
| **High Utilizers of Inpatient services – multiple hospitalizations in a calendar year.** | Providers shall develop (if one does not exist) a child and family team for enrolled children who are high utilizers.<br><br>Providers shall ensure that the child and family team meets during the hospital stay and also communicates with the hospital team for coordination purposes.<br><br>Provider shall coordinate with the inpatient facility to ensure a seamless transition to the community.<br><br>The child and family team shall ensure that the inpatient facility attends to the cultural and linguistic needs of the child and youth.<br><br>Providers shall ensure that families with children and youth in inpatient services have the opportunity for family to family support. | Refine language in the KCMHP P&P to strengthen child and family team coordination and communication with hospital staff. | 2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **Inpatient Coordination cont. High Utilizers** | Providers shall facilitate the shared information between the inpatient hospital setting and the child and family team.<br><br>The provider in partnership with the family will keep the child and family team informed about the child or youth's inpatient status and the inpatient plan on an ongoing basis.<br><br>The child and family team shall utilize the wraparound process in coordinating for discharge and in ongoing outpatient care.<br><br>The child and family team along with the hospital team shall identify the needed skills to prevent further hospitalization and incorporate the acquisition of those needed skills onto the outpatient care plan.<br><br>There shall be identification of children and youth who are high utilizers of hospital care and increased coordination of services for these children, youth, and their families. | Children and youth with multiple hospitalizations will continue to be "flagged" in the King County Information System for clinical care review by MHCADSD.<br><br>Strengthen KCMHP P&P language for children who are high utilizers. | 2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **CLIP Coordination** | There is a continued value in the King County Mental Health Plan to limit the use of restrictive settings and hospitalization for children and youth.<br><br>There will continue to be an interagency mechanism that provides community review to deter, when possible, children and youth potentially voluntarily entering CLIP facilities. Children and youth entering into CLIP who are involuntary will be managed at a different level.<br><br>There will continue to be a mechanism that ensures children and youth are regularly reviewed while in a CLIP facility for continuity of care and discharge planning.<br><br>Every MHP enrolled child or youth entering a CLIP facility will have a child and family team utilizing the wraparound process.<br><br>The Interagency Staffing Teams shall become the "team lead" while children and youth are in CLIP facilities to enhance the coordination of services.<br><br>The child and family team shall ensure that the inpatient facility receives information regarding the cultural and linguistic needs of the child or youth. | Working relationships with hospitals shall emphasize shared care planning between hospital staff and community mental health child and family teams.<br><br>MHCADSD will continue to develop a mechanism to identify children and youth who are involuntarily admitted to CLIP and to possibly provide wraparound services. | 2006 |

## Recommended Continuum of Care

| *Continuum of Care* | *Impact of Guiding Principles on Services* | *King County MHCADSD Action Steps* | *Projected date of accomplishment* |
|---|---|---|---|
| **CLIP Coordination** | The child and family team is informed about the child or youth's inpatient status and the inpatient plan on an ongoing basis.<br><br>The child and family team shall utilize the wraparound process in coordinating for discharge and in ongoing outpatient care to ensure family driven care<br><br>The child and family team shall coordinate with the CLIP facility and other allied systems throughout the length of stay – to expedite return to the community and to participate in care planning, ensuring family driven care and community participation. | There shall be a system of ongoing support from MHCADS to enable providers to facilitate continuity of care for children and youth in CLIP who are enrolled in the Mental Health Plan. | 2005-ongoing |

# Section VII
# Future Administrative Activities Grid

## Recommended Administrative Functions

| ***Administrative Function*** | ***Impact of System of Care Guiding Principles*** | ***Action by MHCADSD*** | ***Projected date of accomplishment*** |
|---|---|---|---|
| **Mental Health Advisory Board (MHAB)** | MHCADSD will maintain a consistent focus on family partnership, family voice and involvement. | MHCADSD in partnership with families shall educate the MHAB and Quality Council about the concepts of family inclusion, family voice, and family partnership in the system of care.<br><br>MHCADSD will recruit parents of children and youth and recruit youth to be members of the MHAB.<br><br>MHCADSD will regularly educate the MHAB on child and family issues to assist the board to maintain a focus on child, youth, and family issues.<br><br>MHCADSD will review and provide input to the MHAB legislative agenda to encourage attention to child, youth, and family issues. | 2005 and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Advocacy** | Systematic and continued emphasis on the needs of children and youth within the system of care. | MHCADSD will continue to exercise leadership within the state and nationally on policy issues related to children, youth and family issues, including: Multisystem involved children, youth, and their families; Children 0-5 and their parents; Children and youth with dual diagnosis and co-occurring disorders (e.g. MH and DD, and MH and CD); Transitional Youth (17-25 year olds) Juvenile Justice involved youth. | Current and ongoing |
| **System Integration of Mental Health and Chemical Dependency** | Systematic integration, to the extent possible, of the mental health and chemical dependency administrative functions. | Incorporate system of care guiding principles into chemical dependency youth serving agency contracts<br><br>Continue to develop shared programs/projects.<br><br>Continue to refine existing shared projects. | Current and ongoing |

## Recommended Administrative Functions

| ***Administrative Function*** | ***Impact of System of Care Guiding Principles*** | ***Action by MHCADSD*** | ***Projected date of accomplishment*** |
|---|---|---|---|
| **System Collaboration** | Systematic communication and coordination in partnership with families, with child serving system leaders to forward system of care principles in all child serving systems. | MHCADSD will maintain dedicated staffing capacity for child serving cross system relationship building and coordination.<br><br>There shall be a commitment of MHCADSD staff that is designated to lead the KCYFSOC.<br><br>There shall be a commitment and staffing capacity within MHCADSD to continue the development and maintenance of relationships with all child serving systems to forward system of care guiding principles in implementing services to families. | Current and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **System Collaboration cont.–** | MHCADSD will continue the commitment to collaborative relationships between all child-serving systems. | There shall be a commitment and staffing capacity within MHCADSD for child cross system activities. | Current and ongoing |
| | Continue to promote cross-system (Juvenile Justice, Child Welfare, Developmental Disabilities, Education, Vocational Services, Medical Services communication, training, information exchange, mutual advocacy, mutual legislative efforts and mutual planning and development).<br><br>Support the identification and appropriate referral of children and youth with mental health issues served by allied systems. | Increase the number of shared projects, including shared funding, for youth and families involved with more than one system<br><br>Continue to refine shared programs to reflect system of care guiding principles.<br><br>Continue Cross Agency Systems Training (CAST).<br><br>Coordinate regular meetings with allied agencies to ensure that programmatic information is up to date and exchanged. | |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Specific System Collaboration with Juvenile Justice** | Increase the collaboration between MHCADSD and Juvenile Justice to ensure that youth with mental health needs are appropriately and effectively served and to reduce incarceration for those youth.<br><br>Continue to work with Juvenile Justice to share responsibility for care planning and services for mutually served youth. | Continue to coordinate with Juvenile Justice to ensure that implementation and outcomes of MST and FFT programs are achieved.<br><br>Maintain and develop formal agreements with Juvenile Justice that delineates shared responsibility between systems (including participation on interagency collaborations) and to define shared roles when serving mutually enrolled youth.<br><br>MHCADSD will participate in cross training efforts with Juvenile Justice to increase knowledge and skill level in working together. | Current and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Role of Medical Director** | The role of the medical director for children and youth services is primarily advisory and a member of the child, youth and family services team.<br><br>Medical direction in child, youth and family services will involve:<br>• membership on MHCADSD teams/committees that direct child/youth and family services in the MH system,<br>• liaison with medically oriented agencies and groups,<br>• participation on key interagency groups devoted to collaborative efforts,<br>• collaborative efforts with youth and/or family groups. | The medical director will support system of care activities through membership on leadership and coordinating committees.<br><br>The medical director will participate as a team member with other MHCADSD staff to implement system of care guiding principles.<br><br>The medical director will assist in shaping policy to implement system of care guiding principles.<br><br>The medical director for child, youth and family services will co-convene a meeting of medical directors from contracted agencies to provide training and elicit support for system of care efforts. | Current and ongoing. |

## Recommended Administrative Functions

| ***Administrative Function*** | ***Impact of System of Care Guiding Principles*** | ***Action by MHCADSD*** | ***Projected date of accomplishment*** |
|---|---|---|---|
| **Contracting** | Contract language is inclusive of child, youth, and family issues (e.g. watches for language such as "client" and ensures the definition of consumer is inclusive of children and their families). | MHCADSD will review all KCMHP P&Ps and contracts to ensure language is inclusive of children, youth and their families. | 2005 and ongoing |
| **Site Visits** | MHCADSD shall maintain a consistent focus on children, youth, and families. | General site visit tools will be inclusive of child, youth, and family issues<br><br>Focused site visits will emphasize recovery-oriented services and specific child and youth issues, such as family partnership. | 2005 and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Evaluation And Performance Measures** | MHCADSD shall maintain a consistent focus on family partnership, family voice and involvement.<br><br>MHCADSD will ensure relevance to children and family issues when developing system outcomes.<br><br>Measurements of effectiveness and quality will include child, youth, and family issues. | MHCADSD will monitor performance measures for children, youth, and families as a means of improving system performance. Special focus will be on measuring family access, voice and choice.<br><br>Special evaluation projects may include children and youth from populations of focus. | 2005 and ongoing |
| **Quality Improvement (QI) Activities** | MHCADSD shall maintain a consistent focus on family partnership, family voice and involvement.<br><br>QI activities involving child, youth, and family issues shall include the participation of children, youth, and families served in the system of care. | A QI project is identified and implemented that focuses on child, youth, and family mental health issues | 2005 and ongoing |
| **Quality Review Team (QRT)** | The QRT will consider a child, youth, and family project. | The Quality Review Team will become knowledgeable about family groups and the issues that are important to the family groups. | 2005 and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Legislative Efforts** | MHCADSD shall be educated about legislative priorities most important to children, youth, and families. | Utilization of existing family/youth groups to assist in identifying top legislative priorities for them.<br><br>Top priorities from the family groups will be forwarded to the Mental Health Advisory Board (MHAB).<br><br>Families shall be invited to attend or participate in the legislative committee of MHAB.<br><br>Families and youth shall participate in legislative forums. | 2005 and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Technical Assistance** | Increased proliferation of the knowledge and skill of professionals/families in the MH community about :<br>• Early Childhood Mental Health Care<br>• Family/Caregiver Perspective<br>• Family/Youth Advocacy<br>• Family/Professional Partnership<br>• Parent/Youth Driven Plan<br>• The Recovery Model<br>• Engagement of families, especially multi-system involved families<br>• Identifying and strengthening needed skills sets of children, youth and families.<br>• Wraparound Process<br>• Utilization of Developmental Milestones in assessment and care planning.<br>• Transitional Youth (17-25)<br>• Information and treatment for emotional disturbances: adhd, bipolar, depression, ptsd. | Support and provision of Technical Assistance to community.<br><br>Publish Developmental Stage Guidelines.<br><br>Publish Practice Guidelines for children 0-5.<br><br>Publish Wrap Around Process<br><br>Initiate the development of Practice Guidelines for transitional youth (17-25).<br><br>MHCADSD shall have the capacity to support trainings as resources allow.<br><br>Continue to utilize local wraparound trainers, consultants and coaches, as resources allow, for implementation of wraparound model. | 2005 and ongoing<br><br>2005<br><br>2005<br><br>2006<br><br>2006<br><br>2005 and ongoing<br><br>2005 and ongoing |

## Recommended Administrative Functions

| *Administrative Function* | *Impact of System of Care Guiding Principles* | *Action by MHCADSD* | *Projected date of accomplishment* |
|---|---|---|---|
| **Technical Assistance** | Increased system capacity to address the needs for children 0-5. | Include child, youth and family partnership, child, youth, and family focus in recovery education training efforts.<br><br>Continued Cross Agency Systems Training (CAST) as resources allow.<br><br>Identify staff in contract agencies with unique qualifications and special interest in children 0-5 and support these staff in participation in cross agency forums.<br><br>Facilitate the increased knowledge and use of DC03 through periodic trainings. | 2005 and ongoing for all |
| **Ombudsman** | Ombuds service staff shall have knowledge and skill in navigating the child serving system. | 2005 Ombuds contract shall reflect child serving system expertise requirement | 2005 and ongoing |

# Section VIII
# Definitions

**Allied Service Provider**
An agency or person representing an allied system that provides direct services to children, youth and their families.

**Allied System**
A governmental organization in close relationship to the mental health system responsible for the provision of services (that are not classified as mental health services) to children and families. Examples include Juvenile Justice, Child Welfare, and Education.

**Best Practices/Promising Practices**
Strategies and approaches that key stakeholders, based on consensus, consider to be effective services for clients with behavioral health needs and their families. These strategies and approaches may not be formally evaluated.

**Blended Funding Project**
A program designed to provide a broad range of community services tailored to the specific needs of the individual child or family, achieved through cooperative agreements and pooled resources from multiple service systems.

**Care Plan**
An action plan mutually developed with the client that describes the services and supports, with clear goals and steps, to achieve recovery.

**Child**
A person between 0-12 years of age receiving services under any children's program.

**Child and Family Team**
A group of people chosen by the child, youth, and/or family that supports them to meet their needs across life domains (emotional, family, housing, safety, recreational, spiritual/cultural). The team is comprised of family members, friends, community members and professionals.

**Children's Crisis Response Services**
Crisis outreach, stabilization, aftercare, and referral services for children and families in crisis.

**Children's Long Term Inpatient Program (CLIP)**
The state appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in the children's long term inpatient programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center).

**Children's Mental Health Plan**
A direction document with action steps to guide King County publicly funded mental health services for children and their families.

**Children's Program**
A mental health program that serves people under 21 years of age.

**Collaborative/Coordinated Services**
The services from one service provider are planned in concert with another agency. Care plans are complimentary between agencies. Ideally, there is one care plan per family that is shared amongst the providers serving the family.

**Culture**
An integrated pattern of human behavior, which includes but is not limited to: Thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature. (From the National Center for Cultural Competence).

**Evidence-Based Practices**
A body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risks for mental disorders, or about the impact of treatment or services on mental health problems." (Burns, B & Hoagwood, K. 2002)[6]

**Family**
A child's family is the group of individuals who support the child emotionally, physically and financially. A family can include individuals of various ages who are biologically related, related by marriage, or not related at all. (National Federation of Families for Children's Mental Health)

**Family Centered**
The family voice is heard and integrated throughout policy, program development, and service delivery. Services have moved from family as client to family as partner. Services are "done with" the family, rather than "done to" the family.

**Family Centered Practices**
The needs and goals of the family are a priority of determining how and when services are rendered. Goals and desired outcomes are mutually defined, as are the resources needed to achieve them. Care planning utilizes existing and potential natural supports.

**Family Friendly**
Actions and environments that promote and welcome family members to actively participate in their care. Examples include: welcoming and culturally relevant artwork, toys, and literature in lobbies, convenient times and locations of service, utilization of everyday language, and communications that are usable to the family.

**Family Partnership**
Contributing to a joint venture with the child and family– usually sharing its risks and benefits. Requires joint decision making power and the shared distribution of benefits or losses.

[6] Burns,B. & Hoagwood, K. (Eds.). (2002). Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. New York: Oxford University Press.

**Inpatient**
A person receiving publicly funded psychiatric services in an inpatient facility, including evaluation and treatment facilities.

**Interagency Staffing Team**
Multi-system regional treatment teams designed to increase cross system understanding and coordination in order to reduce or eliminate barriers to service for the hardest to serve/multi-system involved children and families. See also IST child.

**Managed Care**
An integrated system managing access, intensity and duration of care through defined standards, expected outcomes, quality indicators and planned expenditures.

**Mental Health Plan**
An entity that provides outpatient mental health rehabilitation services and community psychiatric inpatient care (when certified to provide such care) to enrolled recipients, under Agreement with the Single State Agency for Medicaid on the basis of prepaid capitation fees, but is not subject to requirements in section 1903 (m)(2)(A) of the Act as amended. Services are provided through contracted providers.

**Natural Supports**
Any process, activity, or care contributing to positive outcomes that is not a formal treatment or intervention service. Examples of natural supports include mentors, churches, family, friends and community members, and community activities.

**Outreach**
Mental health services provided to KCMHP clients in their places of residence or in non-traditional settings. There are two basic approaches to outreach – mobile (going to them) and drop-in centers (shelters, clubhouses, kitchens, clothing banks, etc.).

**Practice Guidelines**
Systematically developed descriptions of sound care that assist practitioners and clients to make appropriate decisions regarding mental health care for specific diagnoses or concerns. Practice guidelines are usually developed through a process that combines scientific evidence of effectiveness with expert opinion.

**Provider**
A term for contracted agency that provides mental health services within the RSN/MHP. May also refer to a facility or an individual.

**Recovery**
The process in which a client finds what has been lost from his/her life due to illness – the opportunity to make friends, use natural supports, make choices about care, and attend school or find and keep jobs – and to develop personal mechanisms for coping and for regaining independence.

**Regional Support Network (RSN)**
Created as a result of legislative action and responsible for establishment and coordination of a plan for mental health services (residential and community support) for clients/consumers on a regional level through joint operating agreements with the State. The MHP is managed by the RSN.

**Seriously Emotionally Disturbed (SED)**
An infant or child who has been determined to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;
b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;
c) Is currently served by at least one of the following child serving systems: Juvenile justice, child-protection/welfare, special education or developmental disabilities;
d) Is at risk of escalating maladjustment due to:
    i. Chronic family dysfunction involving a mentally ill or inadequate caretaker;
    ii. Changes in custodial adult;
    iii. Going to, residing in or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home or a correctional facility.

**Stakeholders**
A person or group of people who have vested interest in an activity, an action, or an organization. Includes people who are impacted by outcomes of decisions that are made on their behalf; e.g. clients and their families, mental health providers, and allied service providers.

**System of Care**

"A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families." (Stroul & Friedman 1986)

**Transitional Youth**
A person who is between the ages of 13-20 years of age receiving services under any children's program.

**Wraparound Process**
A model of needs-driven and strengths-based planning through a facilitated team process. The child, youth and family are supported by a team of people that includes natural/community supports and professionals, eventually evolving to a team of community supports.

# Appendix A

## List of Documents Available Upon Request

1. **Foundations for the Future**
2. **System of Care Efforts Summary Report 1999-2004**
3. **MHCADS System of Care Survey**
4. **MHCADSD Initiatives with Mental Health & Allied Service Systems**
5. **King County Children & Families Family Involvement Plan**
6. **Family Involvement Model**
7. **King County Youth & Family System of Care Partnership**

# Appendix B

## Populations of Focus

### Children 0 – 5

Very small children and their families are vulnerable to emotional difficulties that may become moderate or severe during their early years and set the stage for lifelong psychiatric problems and mental illness. While timely addressing of mental health problems in this age group is essential for the welfare of these children and their families, and is a requirement for our RSN contract; a coherent mental health plan for this population has distinct preventative benefits as well.

MHCADSD has taken steps to study the needs of this population and to adjust our policy and procedures to better serve children from birth through age 5 (0-5). In April of 2000 King County became the first government entity in the United States to allow diagnoses from a new diagnostic system for very young children, the Diagnostic Classification for Children Zero to Three (DC03). Experts in the field of early childhood mental health have found that using this tool for children 0 through 5 years of age was appropriate. In 2002 MHCADSD chartered a study to assess the impact of DC03 and to better understand how our system addresses the needs of this population. That report also described how the mental health system related to the larger system of care for small children and their families. (Report of the Work Group on DC03, 2002 available upon request). Many of the recommendations of this work group are included in the Children's Mental Health Plan.

The findings of this study showed that provider agencies serve a larger group of children 0 – 5 then expected and that providers had staff who trained and are interested in becoming "specialized" clinicians to this age group. While the codes for DC03 Axis I and II were rarely used, many providers used DC03 as a tool in formulating their evaluations of small children. Many agencies had informal and/or unique relationships with Developmental Centers (funded by DDD), early childhood school readiness programs (funded by school systems), and with other specialized providers such as Childhaven.

In October 2001, in the advent of HIPAA, MCHADSD's direct inclusion of DC03 in our system was not possible due to the requirement that all reporting of diagnoses be in ICD 9 codes. Due to the different theoretical bases for DC03 and DSM and the ICD, MHCADSD recommended to the state Mental Health Division that a crosswalk be developed based on Not Otherwise Specified (NOS), or Unspecified DSM (and ICD) categories. This crosswalk was accepted by the state Mental Health Division although the more recent state Access to Care Guidelines have disallowed some of the DSM diagnoses used in the crosswalk. The use of DC03 remains allowable within the King County MHP. It is an option available to staff whose training and orientation leads to their using DC03 as a useful tool for formulating a case, thus leading to more focused and effective treatment planning for children 0 – 5.

Within existing resources MHCADSD will support and sponsor educational services for staff who are specializing in early childhood mental health. Within the system of care developmental efforts of MHCADSD, the Medical Director will liaison with the Public Health and Developmental Disability systems and their contracted Developmental

Centers, early child education programs, Childhaven, the UW Infant Mental Health degree program, and other providers serving this age group.

Relationships between KCMHP contract agencies and early childhood service providers will be encouraged to the extent that they can be forged through the creative efforts of providers in and out of the mental health system. These may involve consultation, on site outreach service provision, expedited referrals or other forms of relationships.

## Transitioning Youth

Young people who have significant mental health challenges have a particularly difficult task in the process of late adolescence and as they emerge in need of services in the adult system of care. It is a goal of the children's mental health system to facilitate this transition for youth in our care. Responsibility for developing a transition plan, communicating with agencies in the adult system and facilitating a transition sometime between the ages of17 and 21 shall be the primary responsibility of the KCMPHP and providers of the plan who serve children to age 18. It shall be the responsibility of the KCHPHP and adult providers to create relevant programs and assure access for these youth. Both parts of the mental health system shall create a collaborative plan that may involve regular meetings, joint policy statements and staff exchanges, in order to facilitate transitions for youth emerging as adults. The following are guidelines for this process.

## Programming for young adults

The adult system will create treatment structures that are relevant to the needs of young adults. This will involve an understanding of contextual, stylistic and sub-cultural issues that enhance access to care as well as limit access. It will be a goal of such programs to advocate for the removal of barriers that artificially separate youth 18 – 21 from their 16 and 17 year old peers. Programs for young adults should have the capacity to absorb such older adolescents in their programming. This ideal may require advocacy for changes in laws and rules that create limitations for such mixed age groups.

## Substance abuse treatment for young adults

As with teens up to age 18, young adults with a mental illness commonly have co-occurring problems with substance abuse. (See Recommended Administrative changes under mental health/substance abuse integration.)

## Collaboration with child serving agencies terminating their services with youth

Social service, juvenile justice agencies, and public schools all have variable mandates to serve transitioning youth. Youth leaving foster homes and group homes on their eighteenth birthday and youth sent home from a detention facility at age 18 often have no housing and no community support. Child and adolescent clients enrolled in the

KCMHP who are terminated for service by other agencies will be a focus of the MHCADSD. In our collaborative agreements with such agencies, we will assure that they share with MHCADSD the responsibility for an appropriate and realistic disposition into adult services outside of their agencies.

**Housing for Young Adults**

Housing has been identified as the most challenging service to provide for transitioning youth. Efforts to seek funding for housing programs relevant for youth are on-going and will require active advocacy from the KCMHCADS in concert with homeless advocates and other service providers. Most housing in Long-Term Residential facilities is not appropriate for youth and having youth in such programs can be disruptive for the other residents. Housing needs should be identified for 17 to 25 year olds as a special category. The MHCADSD will seek to have a subset of data, especially regarding housing and homelessness highlighting youth 18 – 25. MHCADSD will advocate for liberalizing the rules that disallow youth to remain in a long term foster home if that home has younger children remaining in the home.

## Appendix C

## Evidence Based Practices

The term “evidence-based practices” (EBP) has become widely used in the local, state, and national policy discussions on services for children and adolescents. Evidence-based practice refers to “a body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risks for mental disorders, or about the impact of treatment or services on mental health problems.” (Burns, B & Hoagwood, K. 2002)[1] It is generally used to differentiate research-based, structured and manualized treatment programs that use randomized trial designs from less rigorous or well-tested practices.

While there is currently no national consensus on how to define the term evidence-based, operational criteria for establishing EBPs have been proposed by the Division of Clinical Psychology of the American Psychological Association (1998) and the Substance Abuse Mental Health Services Administration (SAMHSA) is looking to create agreed upon criteria for EBPs. In general, for a treatment or intervention to be considered evidence-based, two or more studies must have shown the treatment to be superior to medication, placebo, or an alternative treatment or equivalent to an already established treatment; or a minimum of nine single-subject case studies must be conducted to establish its equivalence or superiority. In addition, well established treatments must be conducted with treatment manuals and effects must be demonstrated by at least two independent investigators.

The majority of the research on evidence-based practices comes from numerous studies of specific psychosocial or behavioral treatments for youth with a specified emotional or behavioral problem or diagnosis. Examples include manualized cognitive-behavioral therapy for anxiety disorders and for depression. The National Institute of Mental Health (NIMH) Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder found that the combination of medication, cognitive behavioral therapy, parent training, and school intervention was superior to any one treatment alone and to routine community care. Other well established practices include Aggression Replacement Therapy (ART) for assaultive/aggressive behavior, Trauma-focused CBT for traumatic stress and Parent/Teacher Behavior Management programs (i.e., The Incredible Years) for Disruptive and Oppositional Behaviors. Many interventions that have been well studied and proven effective with adult populations are considered promising practices with children and youth as these interventions have not yet been well researched with youth. Examples include Dialectical Behavior Therapy (DBT) for self-harming behavior including eating disorders.

In addition to specific manualized treatments and interventions, several community-based service models have demonstrated effectiveness. These models include Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and ART used to reduce recidivism in juvenile offenders. Additionally, Multi-dimensional Family Therapy and Treatment Foster Care have been proven effective for youth and families with complex and overlapping needs. Finally, a number of mental health problems require medication as the most effective first line intervention. Examples include Bipolar Disorder and Schizophrenia.

Despite the growing emphasis on research-based practice guidelines and empirically supported therapies, the treatment approaches with the best empirical support are rarely used in typical clinical practice (Kazdin et al., 1990; Weersing, Weisz, & Donenberg, 2002). First of all, evidence-based practices are not available for all problems and needs and, even when available, do not necessarily work uniformly across all families and communities. Much of the research on evidence-based treatments and interventions has been conducted in academic laboratory-type settings with children who display a single, well-defined disorder. The intent of designing this type of research study is to prevent the intrusion of potential “confounding” variables. However, these variables often reflect the real-life situations of children and youth presenting with mental health concerns. In the ‘real world’, complicating factors such as co-occurring disorders, lack of family engagement, inconsistent attendance, and social and medical issues may decrease the effectiveness of an evidence-based treatment.

Questions have also been raised about the applicability of some practices with sub-populations not in the original ‘evidence base’. For example, culturally diverse populations, immigrant groups, or populations who live in poverty may have different characteristics and needs than those for whom the original therapy was designed. To date, there is limited research on the effectiveness of evidence-based treatments with minority and other diverse populations and, therefore, the generalizability of these evidence-based practices remains to be determined.

Implementation of evidence-based practice requires not only changes in practice behavior, but a restructuring of programs as well as an infusion of upfront resources for training and supervision. Most treatments that lend themselves to solid measurements demand strict adherence to a research protocol. In clinical settings, this type of strict adherence is difficult to achieve given the complexity of needs and overlapping concerns of families and youth. Without such assurance of adherence the "evidence" of effectiveness may be mitigated and/or washed out.

Finally, systems of care and wraparound have brought along a strong family movement that has highlighted the positive impact of family involvement and family choice in the treatment planning and decision making for their children. Major advocacy and provider groups endorse families as partners in planning. While families want to know what works and what practices are effective, they also need to have a voice in determining what practices, services, and supports address their needs. The move to evidence based practice (EBP) in the mental health system must take into consideration all of the factors that affect carrying out the treatment in the ‘real world’.

Given the limitations of applying an EBP in the real world, the potential costs of achieving adherence, and the fact that much of what must be addressed in patients (especially in children and adolescents) has not been adequately researched, a rigid insistence on funding only EBPs would hinder efforts to care for children and youth.

Many of the psychopharmaceuticals, which are regularly offered to children and adolescents as standard clinical practice, have not been tested. It has been estimated that 80% to 90% of prescribing for children and adolescents is "off label." Disallowing use of commonly prescribed medications for children and youth would be detrimental to the treatment for these clients.

System of care (SOC) methodologies are another example of treatment that has been found to work in the ‘real world’ without the support of rigorous scientific laboratory testing. While its values, principles and certain methods have been applied broadly, SOC and its prime methodology, the wraparound process, have not had a clear definition through specific criteria. Yet it is the most comprehensive of all the systems level practices. Currently it is considered a "Promising Practice" by some and is often included in the list of "Best Practices" which include EBPs. Promising practices are those for which some research and program evaluation evidence exists, and which have a high degree of clinical consensus.

King County MHCADSD recognizes Best Practices, such as SOC with its emphasis on a Wraparound Process and other related promising practices. It also recognizes the applications of certain adult treatments to children and youth, even though the formal research evidence is not as yet available. Our plan embraces EBPs applied as skillfully as possible, given staff resources and training.

The availability of a growing research base on effective clinical treatments and interventions for children and adolescents offers an opportunity to improve the efficacy of mental health services. However, limitations to the evidence base as well as limitations in connecting EBPs to issues of real world implementation suggest the need for new methods of linking research to practice. Creating family-driven, empirically based, high-quality services will require a commitment to ongoing evaluation and feedback.

A system of care approach and evidence-based practice are not competing efforts but complementary. Systems of care focus on improving access, developing a broad array of services and ensuring coordination (Huang, Hepbur, and Espiritu 2003). It provides a context for implementing evidence-based practices. The intent of the wraparound process is to plan and implement the set of services and supports that is most likely to achieve positive outcomes for a family. For some families, this might include delivery of formal treatments with scientific evidence and support. Thus, the movement toward evidence-based practice converges well with a system of care approach.

# Appendix D

## Recovery for Children and Youth with Serious Emotional Disturbance

Recovery has been defined by William Anthony as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles…to live a satisfying, hopeful and contributing life even with limitations caused by [an] illness.”

The primary presumption of a recovery process is that the illness is not the person. The person can transcend the illness if realities of the limitations and risks are acknowledged and personal strengths can be mobilized to engender the satisfaction and hopefulness Anthony describes. We know that youth do suffer from serious emotional disorders. Some of these predict life long challenges to cope while attending to the realities of chronic illness. Some may be more transitory, but create risks for developmental problems that can reverberate into adulthood. How can we adapt the core concepts of recovery to the tasks that children and youth face when they struggle with a serious emotional disorder?

To make this adaptation we must first have a concept of the tasks of childhood and adolescence. We must be mindful of the developmental process in its entirety, but especially as it applies to psychological and social growth. Young people are on a course of development that is relentless. This process demands both the care and attention of adults and a child having the innate capacity for growth. A mental illness can seriously interfere with this process. Furthermore the way that adults respond to a child or adolescent who is seriously emotionally disordered may further complicate the child’s developmental process.

For developing children and youth, recovery must be understood as a process that enables youth and their significant adults to understand and manage the realities of an illness while restoring the developmental process. Recovery oriented services are those that professionals can offer to help children and their significant adults to foster this restoration.

The implications of this concept are that children and adolescents have within them certain capacities that will, if unleashed, propel them on a constructive developmental course. A strength based approach to service provision is a method of assuring that those capacities are indeed unleashed.

Children and youth respond best to mental health workers who can find joy in seeing their clients re-engaged in their developmental tasks, even in the course of a treatment session. As adults working with youth, therapists must first and foremost understand this more primary relationship to the clients they want to serve. Reveling with a youth demonstrating their strengths and serving first as a mentor to that process enables therapists to then help youth identify what they need to make such a process proceed more successfully.